A not-for-profit health and tax policy research organization

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House Energy and Commerce Committee

Subcommittee on Health

Hearing on

H.R. 5613
Protecting the Medicaid Safety Net Act of 2008

The Honorable Frank Pallone, Jr.
Chairman

By Grace-Marie Turner
President, Galen Institute

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P.O. Box 320010 • Alexandria, VA 22320 • Phone 703-299-8900 • Fax 703-299-0721 • www.galen.org

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Mr. Chairman and members of the committee, thank you for inviting me to testify before your committee today about the important issue of Medicaid integrity. To introduce myself, I am Grace-Marie Turner, president and founder of the Galen Institute. Galen is a non-profit research organization devoted to developing and furthering public understanding of solutions to problems in our health sector. I recently completed a three-year term as a member of the Advisory Council to the Agency for Healthcare Research and Quality in the Department of Health and Human Services, and I served as a member of the Medicaid Commission from 2005 to 2006.

One issue on which there is little or no disagreement is the importance of the Medicaid program to the millions of people it serves. It is vital to recipients as well as to taxpayers that Medicaid funds are spent wisely to provide the best care to this vulnerable population, especially as demands increase. Medicaid expenditures and enrollment are projected to grow significantly, with enrollment projected to increase from about 54 million today to 65 million by 2015, a 21 percent increase. In 2015, the program will be spending $685 billion a year, a 145 percent increase over today.

Our Medicaid Commission held numerous hearings in Washington and around the country to gather testimony from experts and citizens about the program.

We heard a great deal about the strengths of Medicaid:

- Medicaid truly is the safety net for our health care system and can be a lifeline for millions of people with low incomes and disabilities.

- Medicaid fills gaps in our private health sector that is dominated by employment-based health insurance, covering millions of people for whom job-based coverage is not an option.

- Because Medicaid is a joint federal-state program, it benefits to some extent from the principles of federalism, allowing Medicaid to be more flexible than Medicare. States have used this flexibility to experiment with programs to better meet the needs of their citizens.

But we also heard about many of the problems with Medicaid:

- Medicaid offers a rich benefits package, but recipients often have trouble finding private physicians who will see them. Patients are often relegated to crowded hospital emergency rooms to receive medical care.

- The care of Medicaid recipients is often uncoordinated among the physicians, clinics, and hospitals where they receive treatment.

- The focus often is how much money Medicaid is spending rather than on whether the money is being spent wisely to produce the best outcomes.

- And while the federal-state partnership provides Medicaid with some limited benefits of federalism, states' flexibility is constrained by extensive rules and regulations which force them to go through long, complex, and time-consuming appeals to request program changes to better meet the needs of their citizens.

One of the most important lessons I learned from our work on the Medicaid Commission is that changes are needed so the program will have the resources to meet its mission in the future.

Medicaid is the biggest item in many state budgets. Governors from both parties told us they don't see how they will pay for Medicaid's escalating costs and also pay for roads, schools, and public safety, and they pleaded for more flexibility and control. Changes need to be made to the program so it can be more responsive to our 21st century health sector, but even small steps toward injecting some spending discipline create a great deal of fear and opposition.

The proposals addressed by the legislation being considered by the committee today were intended to bring more fiscal stability to the Medicaid program. These changes would result in an estimated $13 billion reduction in federal Medicaid spending over the next five years, out of the $1.2 trillion in federal dollars that Medicaid will spend over that time. So these changes represent only about 1 percent of spending, but they could demonstrate a federal will to bring greater integrity into the program.

One example is the proposal to limit states' ability to use intergovernmental transfers, or IGTs. The Government Accountability Office wrote in a study entitled "Intergovernmental transfers have facilitated state financing schemes"[1] about problems that persist:

> For many years states have used varied financing schemes, sometimes involving IGTs, to inappropriately increase federal Medicaid matching payments. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, the large payments are often temporary, since states can require the local-government providers to return all or most of the money to the

states. States can use these funds—which essentially make a round-trip from the states to providers and back to the states—at their own discretion.

States' financing schemes undermine the federal-state Medicaid partnership, as well as the program's fiscal integrity, in at least three ways.

• The schemes effectively increase the federal matching rate established under federal law by increasing federal expenditures while state contributions remain unchanged or even decrease. GAO estimated that one state effectively increased the federal matching share of its total Medicaid expenditures from 59 percent to 68 percent in state fiscal year 2001, by obtaining excessive federal funds and using these as the state's share of other Medicaid expenditures.

• There is no assurance that these increased federal matching payments are used for Medicaid services, since states use funds returned to them via these schemes at their own discretion. In examining how six states with large schemes used the federal funds they generated, GAO found that one state used the funds to help finance its education programs, and others deposited the funds into state general funds or other special state accounts that could be used for non-Medicaid purposes or to supplant the states' share of other Medicaid expenditures.

• The schemes enable states to pay a few public providers amounts that well exceed the costs of services provided, which is inconsistent with the statutory requirement that states ensure economical and efficient Medicaid payments. In one state, GAO found that the state's proposed scheme increased the daily federal payment per Medicaid resident from $53 to $670 in six local-government-operated nursing homes.

Although Congress and the Centers for Medicare & Medicaid Services have acted to curtail financing schemes when detected, problems persist. States can still claim excessive federal matching funds for payments exceeding public facilities' actual costs. GAO suggests that Congress consider a recommendation open from prior work, that is, to prohibit Medicaid payments that exceed actual costs for any government-owned facility.

A CMS rule that would address this problem has been delayed since the final rule was published on May 29, 2007, and would be further delayed by H.R. 5613. Regarding other provisions, such as limiting payments through Medicaid for graduate medical education (GME), CMS is saying that the federal government should exercise its role to make sure that Medicaid funds are being used for Medicaid services. GME is not an allowed Medicaid service. If there are additional services that Congress believes are the responsibility of the federal government, this should be done through an explicit appropriation.

That is the case with many other provisions addressed by the legislation. The Office of the Inspector General for the Centers for Medicare and Medicaid Services (CMS) has reported in testimony before this committee that it is working to "ensure that Medicaid expenditures are in fact used for medical care to Medicaid beneficiaries…Our overarching concern is to ensure that

Federal matching payments are in the proper proportion to States' shares and that the funds are used to provide the intended health care services in the intended facility to the intended beneficiaries. Changes are still needed to enable the Congress and the Department to be responsible stewards of Federal funds and measure the true cost and benefits of the Medicaid program."[2] These payments may draw down a disproportionate share of Federal matching funds but without providing any corresponding benefit to intended beneficiaries.

I would offer a few specific comments about the seven rules that H.R. 5613 would delay:

- Many members of Congress have expressed concern about the CMS rule placing new and lower limits on federal financial participation for state Medicaid payments to government health care providers. However, the HHS Office of the Inspector General has documented numerous instances in which medical facilities, such as nursing homes, have been forced by the states to rebate tens of millions of dollars of these enhanced payments. These extra payments can, in many cases, cause the facilities to operate in the red and compromise patient care. The OIG reported one instance in which a nursing home did not retain enough Medicaid funding to fill all of its nursing positions. The nursing home was significantly understaffed considering the minimum number of nursing positions specified in its budget and recommended for similar-sized nursing homes. The OIG reported that this condition may have affected the quality of care provided to its residents.[3] The CMS rule would require that these providers receive and retain the total amount of the Medicaid payments they are due, without being forced to rebate a portion of the payments back to the states, payments that often are used to help the states offset their share of the Medicaid program or to pay for non-Medicaid services.

- The provider tax provides similar challenges. Health care providers need to be protected from states that are using these taxes to extract revenues from providers to fill state coffers.

- Again, regarding Medicaid payments for graduate medical education: The costs and payments associated with GME are not expenditures which are federally reimbursable under the Medicaid program. The core mission of the Medicaid program is to pay for medical and medically-related services for Medicaid enrollees. If Congress decides to provide additional funds for GME, the appropriation should be explicit and authorized by statute, which is not currently the case.

- The Office of the Inspector General has found numerous cases in which Medicaid claims were being filed that did not involve patient care or allowable rehabilitation services. It found, for example, cases in which the taxpayer was being billed for nonrehabilitative services such as transporting beneficiaries to the grocery store, restaurants, or even bingo games.[4] The government has a responsibility to assure that taxpayers' dollars are being spent legally and for the appropriate and allowed care and services.[5] The same principle holds true for targeted case management and school-based administration and transportation. Many of these services may be needed but are not legal Medicaid expenditures. Unless a check is placed on these expenditures, states could undermine

> Medicaid's ability to provide the needed and allowed medical services that millions of Medicaid recipients rely on.

The GAO and the OIG have identified important areas where this waste and even misuse of Medicaid funds is taking place. The CMS rules may not be ideal, but rather than block the rules completely, a better strategy would be for the Congress to work with the administration and the states to produce policies to address this financial abuse.

The great majority of providers serving Medicaid patients are working to provide the best care possible, often at considerable sacrifice, such as physicians who treat Medicaid patients even if the Medicaid payment means they are taking a financial loss. But there are people who are using the rules to game the system. And even the states, enabled by clever lawyers, have learned how to game the system by drawing as many federal dollars as possible and forcing providers to operate on tight or even non-existent margins. Patient care can suffer.

Many of the abuses in the Medicaid program are rooted in FMAP, or Federal Medical Assistance Percentage, as my Medicaid Commission colleague Bob Helms of the American Enterprise Institute has documented[6]:

> The FMAP procedure of Medicaid financing has been criticized by policy analysts and government agencies for decades.[7] This criticism comes from analysts representing a wide spectrum of policy-oriented and philosophical approaches to health policy, proving that this debate is not just a matter of government budgets. The perverse incentives created by this method of financing would be present at any level of spending. In addition to the AARP report, a recent report from the National Academy of State Health Plans refers to the Medicaid "tug of war" and calls for steps to improve the fiscal integrity of federal financing.[8] The authors of the report point out that the FMAP procedure creates strong incentives for states to engage in accounting schemes that enhance federal funding, and for the federal bureaucracy to attempt to control these schemes--hence the "tug of war." Numerous analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather than consider reforms that would be in the best interest of those Medicaid is intended to serve.

The most important goal, I believe, is to preserve the Medicaid program for the most vulnerable members of our society, those who have few if any other alternatives to support their needs for medical care. If states are allowed to continue to use Medicaid dollars to support other state services and to rob the providers of the resources they need to provide the best care for patients, the program and its recipients will be harmed. Additionally, while many of the functions that states have undertaken with Medicaid dollars may represent legitimate needs, it is important for the integrity of the program and for the legitimate expenditure of federal taxpayer dollars that Medicaid spending follow congressional directives.

The president and CEO of the Mayo Clinic, Dr. Denis Cortese, spoke in Washington recently about health reform. Mayo is renowned worldwide for its expertise in medical diagnosis, and Dr.

Cortese drew on these capabilities to help policymakers think more strategically about health reform. He said in medical care and in public policy, change must focus on putting the needs of the patient first. Patients want personal, high-value health care, and we need to provide better incentives for programs and providers to provide that care.

Micromanagement of the system through rules and regulations is not putting the patient first. Instead, we need to focus on new financial incentives to encourage patients, providers, program administrators, and the states to make sure they are getting the best value in health spending. Rethinking Medicaid's financial structure, I believe, is needed.

Our commission heard many, many witnesses testify that patients want a medical home. The worst place to get routine medical care is in a crowded hospital emergency room, but too many Medicaid recipients have no other choice. Having a medical home would mean that someone is working on their behalf to coordinate care. Medicaid doesn't support the kind of coordination that would lead to better care and more efficient spending.

After hearing hours and hours of testimony during my service on the Medicaid Commission, I believe we must begin the process of transforming this fragmented, procedure-oriented program to one that is focused on coordinated care, results, and outcomes. Quality of care for Medicaid recipients will be improved when health care providers are responding to patients' needs and not to bureaucratic program rules and regulations.

For Medicaid to become more patient-focused and to more effectively meet the distinctive needs of populations with different needs, Medicaid programs must begin funding health care in a new way. Achieving better quality of care is integrally connected to creating new incentives to achieve better outcomes. This means that new funding mechanisms should be tied to the success of providers and health plans in coordinating patient care, gathering sharable information on the patient's medical care, and giving patients more information and responsibility to be partners in managing their health.

Focusing on these goals and on putting patients first would assure taxpayers, states, and most importantly, patients, that the system is supporting quality care.

Thank you for the opportunity to testify today and I welcome any questions.

ENDNOTES

[1] Kathryn G. Allen, "Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 18, 2004, at http://www.gao.gov/new.items/d04574t.pdf.

[2] George M. Reeb, testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 18, 2004, at http://www.oig.hhs.gov/testimony/docs/2004/031804fin.pdf .

[3] "Adequacy of Medicaid Payments to Albany County Nursing Home," U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), June 2004, at http://oig.hhs.gov/oas/reports/region2/20201020.pdf.

[4] "Audit of Iowa's Adult Rehabilitation Services Program," U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), March 2005, at http://oig.hhs.gov/oas/reports/region7/70303041.pdf.

[5] "Audit of Medicaid Claims for Iowa Rehabilitation Treatment Services Family-Centered Program," U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), July 2004, at http://oig.hhs.gov/oas/reports/region7/70203023.pdf.

[6] Robert B. Helms, "The Medicaid Commission Report: A Dissent," American Enterprise Institute, January 11, 2007, at http://www.aei.org/publications/pubID.25434/pub_detail.asp.

[7] Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs*. Vic Miller and Andy Schneider ("The Medicaid Matching Formula: Policy Considerations and Options for Modification") list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications*, GAO/T-HEHS-95-226, July 27, 1995; GAO, "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending," memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO, "Medicaid Formula: Differences in Funding Ability among States Often Are Widened," GAO-03-620, July 2003. For more recent criticisms, see John R. Graham, "Taming the Medicaid Monster," *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at http://www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); and Pamela Villarreal, "Federal Medicaid Funding Reform" (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at http://www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006).

[8] Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at http://www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).